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Communication between hospital doctors: Underaccommodation and interpretability

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ABSTRACT

We examined underaccommodation in hospital medical charts, with a focus on interpretability. In Study 1 147 hospital doctors completed a questionnaire including interpretations of chart entries from their own or another specialty. Study 2 used interviews with 10 doctors to explore interpretations of the same charts and perceptions of the writers. Results indicated that participants interpreted entries by ingroup doctors more accurately than outgroup ones. Interview findings indicated that doctors made excuses for their peers and cast patients as an outgroup. Results indicate that underaccommodation leads to lack of comprehension, which is generally excused by readers.

1. Introduction

Hospitals are complex adaptive systems comprised of multiple-connected or interdependent subsystems (Institute of Medicine, 2001; Plsek and Greenhalgh, 2001). Safe and high-quality patient care is critically dependent on the interaction between these component subsystems, and communication failures are known to cause inadvertent patient harm (Sutcliffe et al., 2004). Communication within hospitals is a central social process, the sum of human interactions within it (Harris et al., 2007). Health care providers are required to cooperate and collaborate for patient care, but they belong to different subgroups, such as departments and specialties, with which they identify more strongly than their profession. In hospitals today more than in the past, care is spread across people and units, so that high-quality care depends increasingly on good collaboration between health professionals. Our research and the studies presented here have focused on communication between doctors during the care of patients requiring coordinated involvement from multiple hospital specialists and health professionals. This form of inter-specialty health communication has been infrequently studied, compared with that of more defined work teams in the operating theatre or intensive care unit (e.g., Lingard et al., 2004; Hawryluck et al., 2002; Bleakley, 2006a, 2006b).

A research focus on this area is important, given the fragmentation of patient care associated with the increasingly narrow specialization of hospital doctors and the prevalence of complex patient journeys. In this context, accommodative communication, and communication that meets the needs of other health professionals, is essential. One key function of communication between health professionals is to give precise and accurate information to each other, particularly across specialty and profession boundaries (e.g., between surgeons and internists, between doctors and nurses). This communication may be face-to-face, or it may be dispersed across time and place, as in the case of medical records. Thus, the use of terms and

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concepts that are not easily interpreted by others who may be treating a patient – in terms of Communication Accommodation Theory, underaccommodation – is a significant problem. The context for our research is the care of patients with upper gastrointestinal bleeding (UGIB), a common high-risk medical emergency that requires urgent and coordinated care by doctors from various specialty departments. We focus on the intergroup dynamics of communication in this context through written medical records.

1.1. Intergroup communication in hospitals

Like other contemporary organizations (cf. Jones et al., 2004), hospitals are intergroup contexts, with people from different professions (e.g., medicine, nursing), different specialties (e.g., emergency medicine, gastroenterology), and different levels (e.g., junior and senior doctors) acting and interacting together. Intergroup communication occurs whenever anyone in a social interaction defines self or other in terms of group memberships (e.g., Harwood et al., 2005). Intergroup communication may be deliberate or inadvertent, expressed in actual behavior or perceptions (or both), involve face-to-face or mediated interaction, and may be interpreted in more positive or negative terms (Giles et al., 1987). The present studies aimed to expand our earlier research on inter-specialty care coordination (e.g., Hewett et al., 2009b) through a close examination of communication in medical records. As we have shown (Hewett et al., 2009a, 2013), this form of written communication is stylized, but it is also an important arena of intergroup behavior, as our research has shown. Here we concentrate on the role of underaccommodation (via the strategy of interpretability) in doctors' written records.

1.2. Communication accommodation theory (CAT)

CAT is an intergroup theory of interpersonal communication that explains how individuals use language and strategic communication behaviors to negotiate social interactions between themselves and others (e.g., Gallois and Giles, 1998; Gallois et al., 2005; Shepard et al., 2001). CAT posits that interactants use various communicative strategies, tactics and behaviors to establish and maintain positively distinct ingroup identities.

Depending upon the sociohistorical context and the interpersonal history of the interactants, CAT posits that individuals adopt an intergroup or an interpersonal initial orientation to an encounter. Speakers are motivated to either accommodate (i.e., to use communicative moves that treat the interlocutor as an individual and show liking or solidarity) or to take a nonaccommodative stance (e.g., to communicate so as to maximize ingroup positive distinctiveness). Communicative strategies and behaviors are adapted, depending on salient group identities and the perceived behavior of the other. During intergroup conflict, nonaccommodation is often the prevailing stance, and strategies and behavior are used to maximize differences between group members.

CAT has been applied in health communication, although mainly to examine patient–practitioner communication (Coupland et al., 1988; Street, 2001, 2003; Street and Giles, 1982; Watson and Gallois, 1998, 1999, 2004). Our research, on the other hand, has concerned communication between health professionals of different groups. We have found that in both written and face-to-face interactions, hospital doctors consistently identify themselves and communicate with their medical colleagues as members of specialty groups. This identification is a source of difficulty when patients require the input of doctors from multiple specialties, as patients with UGIB do. Specialty identity is evoked and significant intergroup conflict occurs when there are ambiguous or contested responsibilities for patient care. Status and seniority facilitate inter-specialty communication, with factors such as interpersonal history and intergroup respect also mediating the impact of intergroup conflict (Hewett et al., 2009b, 2013). Despite its highly stylized format and apparent objectivity, we have found the medical record to be an active medium for displays of specialty allegiance and inter-specialty power plays, including counter-accommodative communication tactics and behaviors. In this paper, we take up recent calls (Gasiorek and Giles, 2012; Giles and Gasiorek, 2013) for more work into perceptions and attributions about nonaccommodation, using the stylized context of medical records.

1.2.1. Underaccommodation

Sometimes nonaccommodation is not intentional, but the result of lack of skill (e.g., empathy with the other person, linguistic competence in the other person's codes), lack of forethought, or lack of resources (e.g., when there are time or other constraints). This is particularly true in the case of underaccommodation – behavior that employs a speaker's own language and communication style, rather than attuning to the conversational needs and resources of others. For example, Coupland et al. (1988) found significant underaccommodation among frail elderly people, who talked about their own topics in their own style, even though younger interlocutors were uncomfortable with this behavior. As Giles and Gasiorek (2013) note, underaccommodation is probably more prevalent than the more frequently studied over-accommodation. Indeed, much behavior that in earlier research was glossed as divergence (a form of counter-accommodation) – for example, the failure to attune by switching to an interlocutor's language (e.g., Giles et al., 1991; Sachdev et al., 2012) – actually involves underaccommodation in the form of maintenance of one's own language. Furthermore, people with communication difficulties ranging from lack of communication skill to serious mental or physical disabilities typically underaccommodate, and others must interpret their behavior and react accordingly (e.g., Cretchley et al., 2010; Baker et al., 2014).